

SYBIL BRAND COMMISSION MEETING
March 18, 2015
Reporting for the month of February 2015

AWOLs: There were **130** AWOLs involving **109** youth: **21** youth AWOLED more than once in this same month.

37 remain AWOL	2 HOME
50 returned to GH	2 CCP
15 are in JH	3 Terminated

Outstanding AWOL detainments from previous months and arrests in February 2015:

15 youth were arrested / detained in February who had AWOLED in previous months. **1** is currently in JH, **6** are in a GH, **7** are in Camp, **1** was terminated, and **0** were placed HOP.

Statistics and Findings regarding AWOLs in February:

- 1) 39% of the AWOL incidents were Hispanic males with a mean age of 16.1 years. The second largest population (23%) of AWOLED youth during the month of February was Black males with a mean age of 16.0 years. Black females and Hispanic females accounted for 18% and 12% respectively. The overall average age of youth who AWOLED in February was 16.2 years.

Recommendation:

- Hispanic males have continued to represent the largest number of AWOL incidents for the past 30 months. The reason for the large number of Hispanic male AWOLs may likely be a representation of the general population of LA County. Even if that is a fact, it still means this is the population that Probation needs to work with to decrease AWOLs. DPOs, Therapists, or other GH and County staff, should interview at-risk youth (mainly Hispanic males around the age of 16) to find out about certain feelings related to age, gender, or cultural stresses and consider possible solutions to decrease these feelings/stresses.
 - Make DPOs and GH staff aware of the demographics that are at most risk of AWOLing. Research and identify possible methods or daily practices of assisting youth to come to a less stressful state of mind.
- 2) The sooner the GH notifies Probation staff of the AWOL, the faster Probation can begin the steps necessary to detain the youth. For the month of February, five (5) of the GHs were non-compliant with notifying Probation about the AWOLED youth within the required time frame.

Recommendation:

- Continue to reiterate to GH staff and to legal guardians of youth the importance of reporting an AWOL as soon as the incident occurs. Specifically, all AWOLs should be reported within 24 hours in order to expedite the issuance of a bench warrant and the recovery of the youth.

Statistics should be shared with GH staff to illustrate the real results of delayed reporting.

- 3) As with previous months, certain GHs showed a higher percentage of AWOLs than other GHs. This was determined by taking the number of AWOLs for that month and comparing it to the number of beds available in the GH (population). It is important to note that youth who AWOLED more than once in the same GH were only counted as 1 AWOL. For February 2015, 7 GHs and 1 RNR had a 30% or higher AWOL rate which is lower than the previous month (12).

Recommendation:

- Continue to track the frequency of AWOLs for each GH and see if a consistent pattern remains amongst the same group homes. At this point, certain GHs have shown to have a consistently high number of AWOLs.
 - Several confounding factors have to be controlled to identify a direct correlation between GH treatment of youth and AWOLs. For example, a high AWOL rate for a GH could only mean that that particular GH gets higher risk youth.
 - Investigate GHs that have an unusually high number of AWOLs compared to other GHs to see possible reasons.
 - Interview youth during investigation.
 - Create a plan of action based on results (directives for GH, staff training, etc).
 - Monitor GH to see if trend has stopped after implementation of programs or directives.
- 4) During the month of February, there was a positive correlation detected between bench warrant requests and timely bench warrant issuance and effect on youth detainment. As in, the longer time it took to issue the bench warrant, the less likely it was for the youth to be detained that same month:

Recommendation:

- Regardless of strong or weak correlations, consider the importance of having a bench warrant issued as soon as possible for an AWOLED youth. Overall, the sooner a bench warrant is issued, the more likely it is that the youth will be detained by the end of the month (as several previous months' data has shown).

Final Remarks on AWOLs: Similar to last month, all 'insignificant' AWOLs were also incorporated into the data this month (i.e. youth Awoling for an hour). Certain trends relating to race, age, and sex continued to mirror the previous months' data.

iTrack (SIRs)-

There were 0 child deaths and 1 suicide attempt reported for the month of February 2015, in the iTrack automated reporting system.

Boys Republic (Main) – A resident became upset that he was not allowed to use the telephone due to it being late at night. He became agitated and was able to retrieve a pair of scissors from a staff drawer. He began attempting to cut his wrist and forearm with the scissors. Another resident was able to persuade the youth to give the scissors

to staff. 911 were called and the youth was placed on a 72 hour 5150 hold at Loma Linda Hospital Behavioral Unit.

For the month of February, the "Other" category for SIRs decreased from second largest category to the fourth largest category which may be related to probation's continued monitoring of all iTrack submissions.

Recommendation:

- Continue to instruct all iTrack users to NOT select the category "other," unless incident undeniably does not belong under any specific category. Another option is to remove the category "other," and instead add additional specific categories (once it is determined why users are selecting "other"). Probation is currently discussing improvement ideas regarding iTrack with ISD software managers.
- Probation is currently tracking all iTrack incident reports, specifically those listed as other, and will continue to provide the findings to the GH's and instruct them to refrain from using the "other" category unless absolutely necessary. It seems like this dialogue maybe the reason the number of incident reports listed as "other" has seen a decrease for the past 4 months. This dialogue will likely continue to decrease the frequency of over utilizing the "other" category; it may also provide the GH's an opportunity to retrain the staff members that continuously select the "other" category instead of properly categorizing the incidents.

GROUP HOME MONITORING AND INVESTIGATIONS:

None of the GH was on Hold status for the month of February 2014.

Child Abuse:

We had 2 referrals for the month of February 2015. 1 was **Unfounded**, and 1 is **Inconclusive**.

Penny Lane (Sat. VII) – General Neglect- The youth is the reporting party that contacted the CA Hotline to report that a GH Counselor, Roscoe Houston refused to give him his medication. The youth reported that this is not that first time that this particular staff refused to give him his medication. The allegation was **Unfounded**.

Phoenix House - Sexual Abuse: Youth alleged that the Music Director/staff (John Morabito) has been touching her inappropriately since the beginning of Feb. 2015. Touching includes the youth's breast, buttocks and attempts to kiss the youth on the lips, grabbing at her waist and buttocks and trying to hug her. He also grabbed her and held her tight while he was heavily breathing on her. The allegation is **Inconclusive**.

Group Home Investigations:

We had 6 Group Home investigations during the month of February 2015. 1 was **Unfounded**, 3 are **Substantiated**, 1 is **Inconclusive / Unfounded**, and 1 had **No Finding**, There were 2 Follow-up investigations for the month of February 2015.

Full Investigations:

Pacific Lodge - Staff Misconduct: Youth is alleging that the reason he went AWOL from the Group Home is because he did not feel safe at the GH, alleging that a staff "Jose" held him for 30 seconds while another youth hit him. Additionally, the youth

alleged that African American youth are treated unfairly in comparison to the Hispanic youth at the GH. The allegation was **Unfounded**.

Crittenton - Youth ingested three white pills that she alleged she found on the kitchen counter in the Willow Cottage. Also looking into other recent medication issues with youth Khariana Houston-Sorrell and a mix up with the CVS Pharmacy and the youth going to the hospital. The allegation is **Substantiated**.

Bayfront - A/C Ombudsman and Probation Ombudsman conducted an "outreach" visit and received several complaints from the youth they interviewed: excessive force used during restraints. Youth feel provoked by staff that knows their "triggers". The grievance process does not work. One youth stated that she was not served full meals and they don't let the girls attend group. The concern is a possible bullying incident. The allegation is **Inconclusive** for excessive force; **Inconclusive** regarding the Grievance process; and **Unfounded** for youth not receiving full meals and Group Therapy.

CAOF (West Hills) - General Neglect (not by GH): Youth was picked up by GH staff from her continuation school and upon pick up, the youth's behavior was erratic. The youth admitted to drinking alcohol and using methamphetamines at the school. By the time the youth reached CAOF's main office for her therapy appointment she became aggressive towards staff and "911" had to be called. She was transported via ambulance to the local ER. The allegation had **No Finding**.

CAOF (Howard House) - Two separate complaints were received from the A/C Ombudsman. First complaint was from an anonymous youth stating that he was embarrassed that a staff was disclosing a sensitive medical issue of his in front of other residents. Second complaint is from a youth stating that the facility vehicle is not working properly which is making it difficult for the youth to keep up with ILP classes. The allegation is **Unfounded**.

Optimist (Main) - Personal rights violation: Youth made a complaint that his educational rights were being violated by the Group Home. The allegation is **Unfounded**.

Follow-up Investigations:

Eggleston (Waco) - Compliance Violation: Youth was transferred to another Eggleston site without prior approval. GH will need to submit a CAP. The allegation was **Substantiated**.

Crittenton - Compliance violation: A staff used poor de-escalation techniques by further escalating the youth's behavior by packing up her belonging. The allegation is **Substantiated**.

Monitoring:

The 2014-2015, fiscal year is in progress and we are currently preparing for the next fiscal year, with a revised compliance tool that Probation and DCFS collaborated on.

Permanency:

We are currently working on 1 potential adoption and 2 potential legal guardianships.

In February 2015, we completed 0 Adoptions and 0 Legal Guardianships.

both allegations
same youth
DCFS
youth